V. S. No. 300
Rev. 10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34598

State File No. 84

FILED NOV 3 1952 REG. DIST. NO. 100 PRIMARY REG. DIST. NO. 3018 Registrar's No. 89

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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
a. COUNTY: Dent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salem
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ~~XXXXXX~~ Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Missouri
b. COUNTY: Texas
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural 1070
d. STREET ADDRESS (If rural, give location): Near Licking Mo 1

3. NAME OF DECEASED (Type or Print): a. (First) Minnie b. (Middle) A c. (Last) Fagan

4. DATE OF DEATH (Month) (Day) (Year): 10/29/52

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: 10/25/78
9. AGE (In years last birthday): 74 (If under 1 year: Months / Days; If under 24 hrs: Hours / Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: x
11. BIRTHPLACE (City and State or Foreign Country): Dent Co Mo C
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: James Mooney
13b. MOTHER'S MAIDEN NAME: Nancy Jane Mooney
14. NAME OF HUSBAND OR WIFE: John Fagon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): x
16. SOCIAL SECURITY NO.: x
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Rose Beirbower Salem Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Verebro-vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis and
DUE TO (c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 331X
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 27 52, to 10/29/52 19, *that I last saw the deceased alive on* 10/29/52 19, *and that death occurred at* 7 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph L Burnett DO
23b. ADDRESS: Salem, Mo
23c. DATE SIGNED: 10/30 52

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 10/31/52
24c. NAME OF CEMETERY OR CREMATORY: Green Foregt
24d. LOCATION (City, town, or county) (State): Salem Dent Co Mo

DATE REC'D BY LOCAL REG.: 10/31/52
REGISTRAR'S SIGNATURE: M. M. Hart M.D by HW
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Carl Lamun Salem Mo

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by_____

_____ Student Embalmer No. _____,

working under my personal supervision.

Student .....
Student Embalmer

Signed Carl K Spencer

Licensed Embalmer No. 2370

P. O. Address Salem Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.